LOW INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP) APPLICATION FOR ASSISTANCE

♦ **Application is not complete without applicant signature on page 2.**

For Agency Office Use Only	
DATE APPLICATION RECEIVED:_____	
DATE APPLICATION COMPLETED:_____	
APPLICATION STATUS: APPROVED DENIED	
CSMS# ASSIGNED:_____	

Type of assistance you are applying for: (Check one)

_____ Energy Assistance _____ Crisis Assistance

Have you received assistance under the LIHEAP program since July 1 of this year through any TN LIHEAP Agency? (circle) Yes No

If yes, which agency provided assistance?_____

Applicant Name:			**Telephone:** **Cell:**
Current Address:	**City:**	**State:**	**Zip:**
County:			
Mailing Address (If different from Current Address):	**City:**	**State:**	**Zip:**

LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT). USE ADDITIONAL PAPER IF YOU NEED MORE SPACE

NAME (must provide first and last name)	MARITAL STATUS	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	RACE (Optional to Provide) White, Black, Hispanic, Asian/Pacific Islander, Native American, Native Alaskan, Other - define	HIGHEST GRADE OF SCHOOL COMPLETED	DOES HOUSEHOLD MEMBER RECEIVE REGULAR FINANCIAL ASSISTANCE FOR A PERMANENT DISABILITY?	HEALTH INSURANCE	INCOME	RECEIVE FOOD STAMPS, SUPPLEMENTAL SECURITY INCOME, FAMILIES FIRST CASH ASSISTANCE (INDICATE ANY RECEIVING)
Applicant Name:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	
Household Member:									Y or N	Y or N	Y or N	

FAMILY TYPE (check one)	DECLARATION OF DISABILITY (Please use additional paper if more space is needed)
Single Parent Female ☐ **Single Parent Male ☐**	**NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:** **DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO**
2 Parent Household ☐ **Single Person Female (no children) ☐**	**NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:** **DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO**
Single Person Male (no children) ☐ **More Than One Adult (no children) ☐**	**NAME OF HOUSEHOLD MEMBER AND PLEASE STATE PERMANENT DISABILITY:** **DOES HOUSEHOLD MEMBER HAVE A SIGNED MEDICAL STATEMENT THAT REQUIRES LIFE SUPPORT EQUIPMENT? (circle) YES NO**

✦***NOTE 1: ASSISTANCE WILL BE DENIED DUE TO AN APPLICANT'S REFUSAL TO FURNISH ALL HOUSEHOLD MEMBERS' SOCIAL SECURITY NUMBERS AND VERIFICATION***✦

(complete both pages)

►**NOTE 2:** ***YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD AGE 18 OR OLDER*** ◄

HOUSEHOLD TOTAL INCOME (Below list income information for applicant and all household members age 18 or older). Use additional paper if more space is needed.

NAME	SOURCE OF INCOME	GROSS MONTHLY INCOME	IF EMPLOYED, PROVIDE EMPLOYER'S NAME & ADDRESS

HOUSING (please check one) ☐ **OWN** ☐ **RENT** ☐ **SECTION 8** ☐ **PUBLIC HOUSING AUTHORITY**

SOURCE(s) OF ENERGY: (Circle)

Wood	Electric	Fuel Oil
Coal	Kerosene	
Natural Gas	L.P. Gas	

HOME ENERGY COSTS:_____

PUBLIC HOUSING/SECTION 8 TENANTS ONLY

Amount of Utility "Overage" $_____

UTILITY or ENERGY COMPANY TO RECEIVE PAYMENT:

Utility Company Name: _____

Utility Company Address: _____

Phone #: _____

Account #: _____

UTILITY or ENERGY COMPANY TO RECEIVE PAYMENT:

Utility Company Name: _____

Utility Company Address: _____

Phone #: _____

Account #: _____

(PLEASE ATTACH STUBS, INVOICES, RECEIPTS, ETC FOR ALL ENERGY SOURCES IN THE HOUSEHOLD)

IF APPLYING FOR "CRISIS" ASSISTANCE, TELL US WHY?

Has your electric or gas been disconnected? Y or N

Have you received a cut off notice? Y or N

***If you have received a cut off notice, please attach a copy.**

I CERTIFY THAT THE ABOVE ACCOUNT(S) IN THE NAME OF _____

IS FOR THE USE OF MY HOUSEHOLD AND I AM RESPONSIBLE FOR ITS PAYMENTS.

IS THIS ACCOUNT IN YOUR LANDLORD'S NAME? Y or N

Has your home ever been served under our Weatherization Assistance Program? Y or N Are you interested in that program? Y or N

Applicant Certification:

I CERTIFY THAT ALL OF THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT. I UNDERSTAND THAT ANYONE WHO FRAUDULENTLY COVERS UP A MATERIAL FACT OR WHO KNOWINGLY GIVES FALSE INFORMATION FOR THE RECEIPT OF LIHEAP ASSISTANCE IS LIABLE UPON CONVICTION TO A FINE OF $10,000 OR IMPRISONMENT FOR NOT MORE THAN FIVE YEARS, OR BOTH. I AUTHORIZE THE VERIFICATION OF ANY AND ALL INFORMATION PROVIDED HEREIN TO DETERMINE MY ELIGIBILITY, AND ACKNOWLEDGE I HAVE BEEN INFORMED OF THE APPEAL PROCESS UNDER PROVISIONS OF THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM. I UNDERSTAND THAT I WILL BE NOTIFIED IN WRITING OF MY ELIGIBILITY STATUS. IDENTIFYING INFORMATION PROVIDED BY YOU FOR DETERMINATION OF YOUR ELIGIBILITY FOR LIHEAP AND FOR THE PROVISION OF SERVICES FROM THE PROGRAM WILL BE CONSIDERED CONFIDENTIAL , UNLESS OTHERWISE AUTHORIZED OR REQUIRED BY LAW, WILL NOT BE SHARED WITH ANY OTHER PERSONS OR AGENCIES EXCEPT FOR PURPOSES DIRECTLY RELATED TO THE ADMINISTRATION OF THE PROGRAM (LIHEAP). I DO____ OR DO NOT ____ AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BE SHARED WITH OTHER AGENCIES FROM WHICH I SEEK ADDITIONAL SERVICES.

APPLICANT SIGNATURE: _____

NO PERSON ON THE BASIS OF HANDICAP, RACE, COLOR, RELIGION, SEX, AGE OR NATIONAL ORIGIN WILL BE EXCLUDED FROM PARTICIPATION IN, OR BE DENIED BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN THE OPERATION OF THE LIHEAP PROGRAM.

To Be Completed By Agency Staff Only:

Number of Household Members Who Are:	
Age under 12 months	_____
Age 2 years or under	_____
Age 3-5 years	_____
Age 60-69 years	_____
Age 70 or older	_____

DATE/TIME TAKEN: _____ ***TOTAL POINTS:***_____

ELIGIBLE BENEFIT LEVEL $_____ ***% OF POVERTY***_____

VOUCHER #: _____

TOTAL ANNUAL GROSS INCOME ALL HOUSEHOLD MEMBERS OVER AGE 18: $_____

SIGNATURE OF DETERMINING AGENCY OFFICIAL:_____ ***DATE CERTIFIED:***_____